State of New Jersey
State Health Ins. Assistance Program
S.H.I.P.
Dept. of Health & Sr. Services
JANUARY 2005

MEDICARE ADVANTAGE POINT OF SERVICE PLANS IN NEW JERSEY

GENERAL INFORMATION				IN NETWORK SERVICES							OUT-OF-NETWORK SERVICES[2]			
COMPANY	COUNTIES WHERE AVAILABLE	PLAN / MONTHLY PREMIUM	ACCEPTS <65 DISABLED	REFERRAL REQUIRED IN NETWORK	COPAY[1] PCP/SPECIALIST	COPAY/DEDUCT. INPATIENT HOSPITAL	COPAY/DEDUCT. SKILLED NURSING FACILITY	EMERGENCY CARE	ROUTINE 1 - DENTAL 2 - VISION 3 - HEARING	Rx DRUGS	ANNUAL DEDUCTIBLE	PLAN PAYS / YOU PAY (COINSURANCE)	ANNUAL MAX COINSURANCE YOU PAY	FOREIGN TRAVEL EMERGENCY
AETNA HEALTH, INC. "GOLDEN CHOICE" 1-800-832-2640 www.aetna.com	BERGEN ESSEX HUDSON MORRIS OCEAN PASSAIC SUSSEX UNION	OPTION 1 $59	YES	NO	$20-25 / $35	$750 / STAY	$25 / DAY DAYS 1-100	$50/ER VISIT (WAIVED IF ADMITTED IMMEDIATELY)	1 - NO 2 - $0 COPAY ANNUAL EXAM, $100/2 YRS. EYEWEAR 3 - $0 COPAY ANNUAL EXAM, $500/3 YRS. HEARING AID	NO (SEE OPTIONAL SUPPLEMENT PACKAGE BELOW)	$150	70 % / 30 %	$ 5,000	YES
		OPTION 2 $89	YES	NO	$10-15 / $20	$250 / STAY	$25 / DAY DAYS 1-100	$50/ER VISIT (WAIVED IF ADMITTED IMMEDIATELY)	1 - NO 2 - $0 COPAY ANNUAL EXAM, $100/2 YRS. EYEWEAR 3 - $0 COPAY ANNUAL EXAM, $500/3 YRS. HEARING AID	NO (SEE OPTIONAL SUPPLEMENT PACKAGE BELOW)	$150	80 % / 20 %	$ 3,500	YES
		OPTIONAL SUPPLEMENTAL PACKAGE FOR MEMBERS IN PLAN OPTION 1 ABOVE: *Outpatient prescription drugs; additional premium $26/month; unlimited generic drugs; $15 copay/30-day supply; $30 copay/90-day mail order supply.* ***OPTIONAL SUPPLEMENTAL PACKAGE FOR MEMBERS IN PLAN OPTION 2 ABOVE:*** *Outpatient prescription drugs; additional premium $50/month; unlimited generic drugs; $15 copay/30-day supply; $30 copay/90-day mail order supply. $200 quarterly limit for preferred AND non-preferred brand name drugs; $25 copay/30-day preferred brand; $35 copay/non-preferred 30-day supply; $50 copay/preferred 90-day mail order supply; $70 copay/non-preferred 90-day mail order supply.*										
	BURLINGTON CAMDEN GLOUCESTER MERCER MIDDLESEX MONMOUTH	$65	YES	NO	$15-20 / $25	$750 / STAY	$25 / DAY DAYS 1-100	$50/ER VISIT (WAIVED IF ADMITTED IMMEDIATELY)	1 - NO 2 - $0 COPAY ANNUAL EXAM, $100/2 YRS. EYEWEAR 3 - $0 COPAY ANNUAL EXAM, $500/3 YRS. HEARING AID	NO (SEE OPTIONAL SUPPLEMENT PACKAGE BELOW)	$150	70 % / 30 %	$ 5,000	YES
		OPTIONAL SUPPLEMENTAL PACKAGE FOR MEMBERS IN PLAN ABOVE: *Outpatient prescription drugs; additional premium $30/month; unlimited generic drugs; $15 copay/30-day supply; $30 copay/90-day mail order supply.*												

1. A separate, different copayment may be required for other services (e.g. physical therapy, medically necessary ambulance services).
2. Prior approval is required for certain services you receive out of network (i.e. non-emergency inpatient hospitalization, psychiatric care.) If you don't receive the required prior authorization, the plan's coverage will be reduced and you will pay a penalty of up to $1000 per service, or the cost of the services, whichever is less. Contact the plan for a list of services for which you must obtain prior authorization. Some services must be received in-network. Contact the plan for details.

(This information may also be found on our web site at www.state.nj.us/health/senior/ship.shtml)

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COMPANY	COUNTIES WHERE AVAILABLE	PLAN MONTHLY PREMIUM	ACCEPTS <65 DISABLED	REFERRAL REQUIRED IN NETWORK	COPAY[1] PCP/SPECIALIST	COPAY/DEDUCT. INPATIENT HOSPITAL	COPAY / DEDUCTION SKILLED NURSING FACILITY	EMERGENCY CARE	ROUTINE 1 - DENTAL 2 - VISION 3 - HEARING	Rx DRUGS	ANNUAL DEDUCTIBLE	PLAN PAYS / YOU PAY (COINSURANCE)	ANNUAL MAX. COINSURANCE YOU PAY	FOREIGN TRAVEL EMERGENCY
HORIZON HEALTHCARE OF N.J., INC. 1-800-224-1234 www.horizonbcbsnj.com	ALL	"Medicare Blue" $57.40	YES	YES	$15 / $20	$750 ANNUAL DEDUCT.	$0	$50/ER VISIT (WAIVED IF ADMITTED WITHIN 24 HRS. FOR SAME CONDITION)	1 - $17 - 28/ORAL EXAM $27 - 44/CLEANING $4 - 52/X-RAYS 2 - $20 COPAY ANNUAL EXAM, $100/2 YRS. EYEWEAR 3 - $0 COPAY ANNUAL EXAM, $750/3 YRS. HEARING AID	NO	$1,000	80 % / 20 %	$ 2,000	YES
	ALL	"Medicare Blue Plus" $89.94	YES	YES	$20 / $30	$750 ANNUAL DEDUCT.	$0	$50/ER VISIT (WAIVED IF ADMITTED WITHIN 24 HRS. FOR SAME CONDITION)	1 - $17 - 28/ORAL EXAM $27 - 44/CLEANING $4 - 52/X-RAYS 2 - $30 COPAY ANNUAL EXAM, $100/2 YRS. EYEWEAR 3 - $0 COPAY ANNUAL EXAM, $750/3 YRS. HEARING AID	$100 Annual Deduct. Unlimited Generic $150 Max./Quarter Brand Name **Formulary** $10/Gen. 30-Day supply $20/Brand 30-Day supply $20/Gen. 90-Day mail order supply $40/Brand 90-Day mail order supply **Non-Formulary** $35/Gen. 30-Day supply $35/Brand 30-Day supply $70/Gen. 90-Day mail order supply $70/Brand 90-Day mail order supply	$2,000	70 % / 30 %	$ 3,000	YES

1. A separate, different copayment may be required for other services (e.g. physical therapy, medically necessary ambulance services).
2. Prior approval is required for certain services you receive out of network (i.e. non-emergency inpatient hospitalization, psychiatric care.) If you don't receive the required prior authorization, the plan's coverage will be reduced and you will pay a penalty of up to $1000 per service, or the cost of the services, whichever is less. Contact the plan for a list of services for which you must obtain prior authorization. Some services must be received in-network. Contact the plan for details.

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